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Assessing Patients Emotional and Spiritual Needs

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Background: A comprehensive, systematic literature review and original research were conducted to ascertain whether patients' emotional and spiritual needs are important, whether hospitals are effective in addressing these needs, and what strategies should guide improvement.

Methods: The literature review was conducted in August 2002. Patient satisfaction data were derived from the Press Ganey Associates' 2001 National Inpatient Database; survey data were collected from 1,732,562 patients between January 2001 and December 2001.

Results: Data analysis revealed a strong relationship between the "degree to which staff addressed emotional/spiritual needs" and overall patient satisfaction. Three measures most highly correlated with this measure of emotional/spiritual care were (1) staff response to concerns/complaints, (2) staff effort to include patients in decisions about treatment, and (3) staff sensitivity to the inconvenience that health problems and hospitalization can cause.

Discussion: The emotional and spiritual experience of hospitalization remains a prime opportunity for QI. Suggestions for improvement include the immediate availability of resources, appropriate referrals to chaplains or leaders in the religious community, a team dedicated to evaluating and improving the emotional and spiritual care experience, and standardized elicitation and meeting of emotional and spiritual needs. Survey data suggested a focus on response to concerns/complaints, treatment decision making, and staff sensitivity.

Researchers' interest in the connections between mind and body[1,2] coincides with increasing interest in the holistic view of health care, in which emotional and spiritual needs are considered inextricable from physical and psychological needs.[3–10] The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has acknowledged that patients' "psychosocial, spiritual, and cultural values affect how they respond to their care"[11](p. RI-8) and has addressed spirituality and emotional well-being as aspects of patient care. For example, Standard RI.1.3.5 refers to "pastoral care and other spiritual services."(p. RI-15) The intent for Standard RI.1.2.8, "The hospital addresses care at the end of life,"(p. RI-13) refers to "responding to the psychological, social, emotional, spiritual, and cultural concerns of the patient and family."

Hospitals have often assigned the responsibility to address emotional and spiritual issues to chaplains or to pastoral teams. Yet others — nurses, physicians, clinicians, and other caregivers—play equally important roles. The hospital staff's ability to address patients' emotional and spiritual needs factors in to patients' perceptions of the overall experience of care, the provider, and the organization. For example, as Shelton observed:

> Patients need to feel that their circumstances and feelings are appreciated and understood by the health care team member without criticism or judgment. . . . If patients feel that the attention they receive is genuinely caring and tailored to meet their needs, it is far more likely that they will develop trust and confidence in the organization."[12(p. 63)]

No comprehensive literature review currently exists to guide hospitalwide management of patients' emotional and spiritual needs. This article provides a literature review of hospitalized patients' emotional and spiritual needs and presents survey findings on the importance of these needs in patients' perceptions of care. Three questions are addressed:

1. Are patients' emotional and spiritual needs important?
2. Are hospitals effective in addressing these needs?
3. What strategies should guide improvement in the near future and long-term?

Methods

Literature Review

A PUB MED search[13] produced no systematic literature reviews on the topic of addressing patients' emotional, spiritual, and psychosocial needs (as of August 18, 2002). Literature identified for inclusion in this review was obtained through numerous structured searches of PUB MED, EBSCO, ScienceDirect, InterScience, University of London Library, and City University of London Library databases and evaluation of key supporting references cited within these sources. To be included, literature reviews or studies had to examine some emotional or spiritual variable (for example, not exclusively religious variables such as attendance at religious services) within an acute care setting. Studies entailing both religious and spiritual measures were included, but our focus was on the latter.

Patient Satisfaction Survey

Patient satisfaction data were derived from the Press Ganey Associates national databases. Patient satisfaction with the experience of care is assessed through a questionnaire mailed shortly after a patient's discharge from an acute care facility. The survey instrument uses a five-point Likert-type response scale (1 = very poor; 2 = poor; 3 = fair; 4 = good; 5 = very good), which provides reliable (Cronbach alpha score, 0.98) and valid measures of patient satisfaction.14 The standard survey includes 49 questions in 10 separate areas, covering the entire patient experience from admission to discharge. One of these questions addresses "the degree to which staff addressed your emotional/spiritual needs." Analyses utilized Press Ganey's 2001 National Inpatient Database, containing data for 1,732,562 patients, collected from January 2001 to December 2001 and representing 33% of all hospitals in the United States and 44% of all hospitals with more than 100 beds.

Results

Are Emotional and Spiritual Needs Important?

Patient Perceptions of Emotional and Spiritual Needs. Evidence reveals parallels between perceptions of emotional and spiritual needs. Definitions of *spirituality* consistently include the psychological concept of a search for meaning and hope.[15–21] For patients who identify spiritual needs, those needs directly involved a range of emotions experienced during hospitalization, including a search for meaning, transcendence, desire to maintain formal religious practices, alleviating fear and loneliness, and the presence of God.[16,22–26] Emotions and spiritual needs also interrelate on a clinical level: Spirituality has been shown to be associated with decreased anxiety and depression.[27–32] Increased use of spiritual practices among persons with AIDS has been associated with a decrease in psychological distress and depression and an increase in emotional coping ability.[33,34] The Systems of Beliefs Inventory, developed to measure spirituality and religious practices in medical populations, recognizes the overlapping emotional, cognitive, behavioral, and social elements of spirituality.[35] Furthermore, emotions and spiritual needs are consistent with patients' perceptions of a single self where all needs intermingle.36 The notion that caring for

emotional and spiritual needs employs behaviors and interventions of a similar nature—support, sensitivity, empathy, comfort, affirmation, and attentiveness to patients' unique needs—is supported by the literature and in the data analysis of the survey results.

Impact on Health Outcomes. Poor psychological and emotional health damages physical health outcomes. A review of emotional distress and coronary heart disease reported that depression, stress, anger, and negative emotions in general were strongly associated with increased cardiac death and reinfarction, independently of disease severity.[37] For example, Pratt et al.[38] confirmed that depression increases the risk of myocardial infarction (MI), and Anda et al.[39] found that depression and feelings of hopelessness were associated with increased mortality from ischemic heart disease.

Conversely, emotional well-being has been shown to be predictive of survival and functional independence among older patients.[40] The widely accepted causal relationship between social support and physical health[41] could be the product of reduction in emotional distress.[42] In a vicious "cycle of decline" between psychological distress and perceived health, psychological distress would lead to increased negative health perceptions, which, in turn, would lead to increased distress and further deterioration in perceived health.[43]

Health outcomes can be positively affected by attempts to address emotional and psychosocial needs. Two studies noted positive physiological responses resulting from the emotional comfort of spirituality.[44,45] Through in-depth patient interviews, Kent et al.[46] found anxiety, depression, and other poor outcomes to be common among patients with unmet emotional needs. Three studies found that psychosocial interventions reduced mortality rates among cancer patients.[47–49] Appropriate, well-considered responses to emotional distress in cancer patients have been found to reduce psychological morbidity.[50,51]

Psychosocial interventions benefit patients through improved quality of life, emotional adjustment, functional adjustment, and psychosocial functioning.[52,53] Metaanalyses indicate positive clinical effects and decreased anxiety from preemptive psychological interventions that target patients at risk of psychological distress.[53] Studies by Blumenthal et al.[54,55] have found that stress management interventions reduce cardiac morbidity. Reducing emotional distress in patients with coronary heart disease improves long-term prognosis.[56] Numerous literature reviews confirm that psychoeducational interventions improve clinical outcomes (for example, anxiety, depression, pain) while reducing length of stay.[57–62] Finally, spiritual and psychosocial interventions have been shown to help patients cope with disease and the effects of hospitalization.[63–65]

In summary, these studies suggest that emotional and spiritual needs have a profound effect on patients' health outcomes and deserve the attention of health care professionals.

Impact on Hospital Finances. Psychological distress and poor psychological well-being may result in increased usage of medical services.[66] Patients hospitalized for physical illness and later identified as being depressed were found to have longer hospital stays, use more hospital resources, and increase costs by 35%.[67–70] Increased usage of medical services by the psychologically distressed has been confirmed in terms of medically justifiable visits and illness reports.[71] Although increased usage, prima facie, may seem desirable to a hospital's finances, preventable usage strains the overall health care system and siphons the attention of a hospital's limited human capital.

Unmet emotional needs have been associated with desires to discontinue patronizing a specific hospital as patients "became disillusioned about the services provided."[46(p. 189)] Poor interpersonal care increases malpractice risk,[72–74] and good interpersonal care reduces

it.[75,76] Testimonials from persons involved in medical error lawsuits suggest that lawsuits "are filed not just for financial reasons but because people feel abandoned and aggrieved, in ways that better communication and acknowledgement might alleviate."[77(p. 241)]

Prevalence of Emotional and Spiritual Needs. Problems such as depression, anxiety, and posttraumatic stress disorder occur frequently (20%–33%) among patients with cancer,[78,79] patients with advanced disease,[80] patients in the intensive care units (ICUs),[81] and generalmedical inpatients.[67] Moreover, levels of clinical depression severely underrepresent patients' experiences of negative emotions such as anger, fear, loneliness, sadness, and hopelessness.[82] The only study that has measured hospitalized patients' experiences of these emotions found that more than 70% of 1,124 discharged emergency cardiac patients reported experiencing problematic emotional reactions four months postdischarge.[83]

Even the most conservative estimates suggest that emotional distress almost always accompanies hospitalization. Hughes[84] found that depression arose among inpatients *before* any diagnosis, "apparently as a reaction to social stress."(p. 15) Scragg et al.[81] found that not only did 38% of patients in the ICU experience major symptoms of posttraumatic stress disorder but that "a proportion of the post-traumatic stress reported was directly attributable to the experience of treatment in the intensive care unit."(p. 9) In support of the notion of a more complex relationship between distress and trauma, a recent study has established that posttraumatic stress disorder symptoms do not simply increase with injury severity.[85] The fact

Table 1: 2001 National Inpatient Priority Index

Question	*n*	Mean Score	Correlation with Overall Mean Score
Response to concerns/complaints made during your stay	1,338,288	81.4	0.79
Degree to which hospital staff addressed your emotional/spiritual needs	1,344,962	80.7	0.75
Staff sensitivity to the inconvenience that health problems and hospitalization can cause	1,440,839	82.7	0.80
Staff effort to include you in decisions about your treatment	1,333,702	82.3	0.79
How well the nurses kept you informed	1,624,052	83.8	0.76
Waiting time for tests or treatments	1,445,249	77.5	0.64
Accommodations and comfort for visitors	1,461,712	81.7	0.68
Staff concern for your privacy	1,543,537	84.0	0.75
If you were placed on a special/restricted diet, how well it was explained	935,104	72.3	0.60
Overall cheerfulness of the hospital	1,642,656	85.5	0.80

that hospitalization can be preceded by severely distressing events, such as trauma or medical diagnosis of a long-term illness,[86] should further reinforce (and possibly compound) the saliency and prevalence of emotional distress during hospitalization.

According to national public opinion research, 79% of Americans believe that faith aids in recovery, and 56% believe that faith has helped them recover[87]; 87% of Americans consider religion to be "very important" or "somewhat important" in their life.[88] In another survey, 77% of hospital inpatients stated that physicians should consider patients' spiritual needs, and 48% wanted their physicians to pray with them.[89] Studies have found that religion and spirituality are used as common coping strategies,[90–92] with positive effects on emotional wellbeing sufficient to improve the patient's ability to cope with illness.[93–96]

Patients' Evaluations of Meeting of Emotional and Spiritual Needs. Analysis of 2001 Press Ganey National Inpatient data (N = 1,732,562) shows "the degree to which staff addressed emotional/spiritual needs" to be highly correlated (r =.75) with the overall patient satisfaction mean composite score. Emotional and spiritual needs rank second on the 2001 National Inpatient Priority Index (Table 1, page 4)—as they have ranked every year since 1998. This analysis combines the performance measure (mean score) with relative importance to patients (correlation with overall mean score). These data demonstrate the following:

- Patients place a high value on their emotional and spiritual needs while in the hospital
- A strong relationship exists between the hospitals' care of patients' emotional and spiritual needs and overall patient satisfaction
- Care for patients' emotional and spiritual needs constitutes a significant opportunity for improvement for most hospitals

The existence of a strong relationship between overall patient satisfaction and emotional and spiritual needs confirms the results of previous studies. Ong et al.[97] found that oncologists' socioemotional behaviors affected cancer patients' visit-specific and global satisfaction. Gustafson et al.[98] found that information and emotional support needs were more important to patients than all other care delivery needs or service concerns. Greenley et al.[99] demonstrated lower patient satisfaction among persons with increased emotional distress. Bertakis et al.[100] observed a relationship between patient satisfaction and physicians' response to emotional needs. Burroughs et al.[101] found that "compassion with which care is provided" had the paramount effect on patients' intentions to recommend/return. Finally, Zifko-Baliga and Krampf[102] demonstrated that negative evaluations of emotional dimensions of care negatively affected evaluations of technical

Table 2: Correlates of Patients' Evaluation of "Degree to Which Staff Addressed Emotional/Spiritual Needs"

Question	Pearson's *r**	*N*
15. Response to concerns/complaints made during your stay	0.75	1,212,147
16. Staff effort to include you in decisions about your treatment	0.73	1,205,854
12. Staff sensitivity to the inconvenience that health problems and hospitalization can cause	0.73	1,263,285
02. How well staff worked together to care for you	0.65	1,320,218
11. Staff concern for your privacy	0.65	1,307,143

*p<.001

quality. These results all support the seminal theories of patient satisfaction as an emotional response to events[103] and the current understanding of patient satisfaction as a summation of all the patient's experiences in the hospital without distinction between service and technical care.[104]

Correlates of Patients' Evaluations of the Degree to Which Staff Addressed Emotional and Spiritual Needs. Analysis of the survey data (Table 2, page 5) revealed that 3 of the 49 questions were highly correlated with the emotional and spiritual needs question: staff response to concerns/complaints, staff effort to include patients in their treatment decisions, and staff sensitivity to the inconvenience that health problems and hospitalization can cause. Two other questions were moderately correlated. Linear regression analysis showed that a variety of variables did not predict patient perceptions of the "degree to which staff addressed emotional/spiritual needs" (Table 3, below).

Discussion

Are Patients' Emotional and Spiritual Needs Important?

The literature review provides strong evidence that emotional and spiritual needs affect health outcomes and hospital financial outcomes, and the survey reveals a strong relationship between the "degree to which staff addressed emotional/spiritual needs" and overall patient satisfaction. Care for patients' emotional and spiritual needs can therefore be considered a component of overall health care quality.

Are Hospitals Effective in Addressing These Needs?

The results from the literature and the survey confirm that most patients experience some form of emotional distress or negative emotions and that hospitals do not wholly address these emotional and spiritual needs. A straightforward interpretation of these results depicts an emotionally and spiritually satisfying in-patient experience, as follows:

- Patients' and/or families' needs are handled in a timely, considerate, and empathetic way
- All tests, interventions, and treatments are explained in an emotionally sensitive and supportive decision-making process
- Staff demonstrably provide empathetic emotional support

Much research needs to be done to formulate a strong evidence base for the effects of specific emotional and spiritual care interventions on patient satisfaction. In the meantime, to address hospitals' needs for guidance on how to satisfy patients' emotional and spiritual needs, some suggestions will be proposed on the basis of the limited literature and from the experience of hospitals that have shown improvement in meeting those needs.

Fully meeting patients' emotional and spiritual needs involves a foundational infrastructure, which may include the provision of basic resources, persons to meet religious needs, an emotional and spiritual care quality improvement (QI) team, customized interventions, and a standardized elicitation of patients' emotional and spiritual needs. Response to patients' concerns/complaints, inclusion of patients in treatment decisions, and staff sensitivity to the inconvenience that health problems and hospitalization can cause can all

Table 3: Linear Regression Analysis of "Degree to Which Hospital Staff Address Your Emotional/Spiritual Needs"

Variable	*R*	*R* Square
Age	0.033	0.001
Sex	0.022	0.000
Days in hospital	0.001	0.000
First stay	0.003	0.000
ER admission	0.028	0.001
Unexpected admission	0.023	0.001
Roommate	0.060	0.000
Self-described hlth status	0.098	0.000

serve as foci for improvement in emotional and spiritual care.

Suggestions for Improvement

Basic Emotional and Spiritual Care Resources. Basic emotional and spiritual resources to support patients' and families' spiritual beliefs and practices include books, multimedia, and support groups (Table 4). Tape and compact disc versions of books should also be available because reading can be a physical strain. Music, a common source of comfort, can reduce clinical anxiety during the course of normal care.[105] Having meal choices for each religion will ensure that, at a minimum, no patient is forced to violate his or her religious or spiritual beliefs or practices during the course of a hospital stay.[106] Support groups with facilitators well-versed in the illness and appropriate coping strategies can provide expertise and reassurance. A quiet, secluded space should be set aside as a chapel or other place for meditation or prayer. Some hospitals have been able to renovate or build such spaces via donations from local businesses, religious organizations, or donors.[107] This minimum sustenance for patients' and families' emotional and spiritual needs ensures a modicum of emotional comfort. An emotional and spiritual care improvement team can analyze qualitative and quantitative patient data to identify resource needs of their own patient population (or varied needs by unit, diagnosis, and so on).

Chaplaincy/Pastoral Care Team. Chaplains/pastoral care teams can provide patients with an in-depth spiritual care experience that results in emotional comfort and improved satisfaction.[108,109] A chaplaincy - pastoral care team can coordinate the elements of an emotional and spiritual infrastructure across

Table 4: Resources for an Emotional/Spiritual Support Infrastructure

Books
- Bibles (different versions)
- Koran
- Torah/Talmud
- Popular spiritual books (e.g., *The Path to Love, Chicken Soup for the Soul, The Dalai Lama's Book of Wisdom, Book of Questions, Tuesdays with Morrie, Handbook for Mortals, Crossing the Threshold of Hope,* poetry collections, photo books, children's books)

Music
- Via compact disc, tape, video, DVD, or Internet
- Classical
- Nature
- Concerts
- Local musicians

Multimedia
- Meditation/relaxation
- Guided imagery
- Popular movies/TV shows
- Internet
- Video games
- Educational (e.g., health, stress management, Bill Moyers' *On Our Own Terms*)

Meditation/Prayer Room/Chapel
- Comfortable furniture
- Soft and soothing light
- Sound-proof
- Candles
- Incense
- Prayer rugs
- Kneeler
- Prayer cards (multifaith)
- Prayer/message book
- Contact information for chaplains/pastoral care and/or local clergy

Support Groups
- Disease-specific (e.g., breast cancer, cancer, AIDS, Alzheimers)
- Faith-based and non-faith-based
- Community-based or hospital-based
- Sociocultural groups (e.g., ethnicity, age, gender)
- Addiction recovery/12-step
- Spirituality
- Family members
- Social

disparate organizational boundaries. An isolated chaplaincy/pastoral care team exclusively responsible for patients' emotional and spiritual needs will be unlikely to influence organization-wide behaviors and processes needed to address patients' emotional and spiritual needs. Instead, the team should collaborate with the physicians, nurses, and staff[110]—who should know when and how to refer patients for pastoral care.[111] The participation of pastoral care team members in standing multidisciplinary teams (for example, discharge planning or continuity of care) and QI teams provides an ongoing opportunity to represent patients' emotional and spiritual needs. If dedicating full-time equivalent (FTE) positions to pastoral care represents an infeasible proposition, empowered volunteers, part-time personnel, parish nurses, and community or in-house networks may be used. One nonreligiously affiliated hospital recognized for its capacity to serve spiritual needs created two support networks:

- A communication network of local pastors/religious leaders, notified by the hospital staff when a parishioner is admitted (with appropriate Health Insurance Portability and Accountability Act [HIPAA] permissions)
- A network of nurses trained to support the prayer needs of patients who visit the patient on request[107]

If religious clergy are not on site, building and maintaining a network of clergy willing to serve patients in varying capacities helps ensure care for those in emotional and spiritual crises — but to address the JCAHO standard, it is essential to meet the patient's request to be seen while he or she is in the hospital.[11]

Multidisciplinary Emotional and Spiritual Care QI Team.

A multidisciplinary QI team charged with improving emotional and spiritual care can coordinate resource additions, organizational learning of communication skills, and interventions. The efficacy of improvement initiatives can be tracked by measuring patients' evaluations of "how well staff addressed emotional/spiritual needs" and benchmarking on a national level. Improvements in normative scores or percentile rankings, variation reduction, or other standard QI methodologies may be used. Senior leadership must empower the team to carry out organizationwide changes with minimal approval procedures and maximum support. Doing so will speed implementation time, facilitate cooperation, and engender connectivity between pastoral care, physicians, nurses, administration, and all hospital staff.

The emotional and spiritual care QI team—or another team charged with this goal — can research and implement emotionally and spiritually supportive individualizing interventions. Patients strongly desire individualized attention from hospital staff.[46] If nurses are to provide individualized care, they need to be knowledgeable about each patient's uniqueness, with time spent with the patient as an important factor.[112,113] Yet rather than generically instructing staff to "spend more time with" or "get to know" patients, structured interventions can guide staff and simultaneously illuminate patients' unique personal aspects and needs. Using the storytelling tradition, clinicians may write an illness narrative with patients and family members.[114] At Great River Medical Center (West Burlington, IA), patients and caregivers together construct the patient's story, and the resulting "living history" becomes a permanent component of the medical charts.[115] A similar method would be to query patients about their personal goals for the hospital stay, medical procedure, or recovery period; goals are written into the medical charts and tracked (with the patient or by the patient on his or her own). Other interventions to consider include relaxation techniques, stress management education, disease-related education, prayer groups, counseling, yoga, tai-chi, meditation, massage therapy, art programs, horticulture therapy, and bedside access to the Internet. Offering patients enticing choices of how to spend their time allows self-customization of the stay that is highly conducive to the patients' own unique needs.

Table 5: Screening Questions

- "What can I do to support your faith or religious commitment?"
- "Are there aspects of your religion or spirituality that you would like to discuss?"
- "Would you like to discuss the spiritual or religious implications of your health care?"

*Matthews, D.A. et al.: Religious commitment and health status: A review of the research and implications for family medicine. *Arch Fam Med* 7:118-124, Mar.-Apr. 1998.
+ Source: Maugans T. A.: The SPIRITual history. *Arch Fam Med* 5:11-16, Jan. 1996.

Standardized Elicitation of Emotional and Spiritual Needs. Identification of patients' spiritual needs demands communication. At certain times, the compassionate presence of a clinician may be enough to fulfill some patients' emotional and spiritual needs.[116] At other times, presence or a single psychosocial intervention may leave spiritual needs unmet.[117] Because most patients desire discussion of spiritual issues, clinicians may ask simple screening questions that will not offend those who decline (Table 5, above).[118–120] Depending on the response, a standard spiritual assessment, for which various tools exist, can follow.[121–125] A spiritual assessment provides caregivers with a brief, easy-to-remember, structured interaction with the patient, resulting in documented knowledge of a patient's preferences, beliefs, and emotional and spiritual needs. An assessment ends with staff action to address the patient's expressed needs. The assessment process, information gathered, documentation, and subsequent assessments can provide invaluable information regarding the patient's treatment preferences, compliance, advance directives, changes, psychological and emotional well-being, and medical information that would otherwise go undetected.[9,126]

In discussing emotional and spiritual needs with the patient, staff may be asked to pray with the patient and/or family. One need not believe in or endorse patients' belief systems or prayer practices, but one can consider showing support for a patient by standing in silence as a chaplain, clergy member, or pastoral care professional leads prayer.[126–131]

Responses to Patients' Concerns/Complaints. The strong correlation between the survey questions regarding "response to concerns-complaints made during your stay" and "the degree to which staff addressed your emotional-spiritual needs" (Table 2) suggests that some component of the care given failed to meet the patient's expectations and provoked a concern that was expressed to at least one member of the hospital staff. The initial concern may be emotional or spiritual in nature and/or may already be a source of emotional distress. Staff's failure to address this concern in a timely and emotionally affirming manner would likely result in a patient's experiencing negative emotions and continued distress.[132] Improving hospitals' service-recovery processes offers good prospects for short-term improvements. Resources to guide construction of an empathetic service recovery process are available.[133–136]

Staff's Efforts to Include Patients in Treatment Decisions. The survey question regarding "staff effort to include you in decisions about your treatment" encapsulates the interactions experienced within the treatment decision-making process, including communicating potential diagnoses, explaining testing and test results, and providing patient education and support when the treatment decision is made. This does not mean blind acquiescence to whatever the patient desires. Communication skills play a critical role in providing information and reaching decisions in a patient-centered way that does not compromise the patient's health.[137] Standardized assessments may prove critical—and, as some contend, even mandatory—in collaborating with patients to arrive at serious treatment decisions that are consistent with patients' values.[10] Even if the specific course of treatment and the decision-making process satisfy patients, if the experience leaves patients or family members uncertain, apprehensive, fearful, or worried, emotional and spiritual needs will remain unmet.

Table 6: Phrases to Help Elicit the Patient's Concerns*

1. Use open-ended questions.
- Does your trust in God lead you to think about cardiopulmonary resuscitation in a particular way?
- Do you have any thoughts about why this is happening?

2. Ask the patient to say more.
- Tell me more about that.
- Can you tell me, what do you think about this?

3. Acknowledge and normalize the patient's concerns.
- Many patients ask such questions.

4. Use empathic comments.
- I imagine I would feel pretty puzzled to not know.
- That sounds like a painful situation.

5. Ask about the patient's emotions.
- How do you feel about...?
- How has it been for you with your wife in the intensive care unit for so long?

* Adapted from Lo B., et al.: Discussing religious and spiritual issues at the end of life: A practical guide for physicians. *JAMA* 287: 749-754, Feb. 13, 2002. Reprinted with permission.

The treatment decision-making episode usually involves a physician who assumes the responsibility of helping the patient and family through the difficult juncture. Improving physicians' communication skills (handling emotions and defining problems) has been shown to reduce patients' emotional distress for up to six months.[138] Physicians who can truly understand their patients and communicate effectively are better positioned than others to provide the emotional support that patients need,[139] and better emotional care by physicians results in better health outcomes.[140]

The American Medical Association (AMA) Working Group on Religious and Spiritual Issues at the End of Life constructed suggested phrases that physicians may use to encourage patients' to express their emotional and spiritual concerns.[129] Usage may be broadened beyond imminent end-of-life decisions.

Table 7: Standard Communications and Behaviors

Empathic Communications
- "This must have been a very (fill in appropriate word: frightening, painful, upsetting) experience for you"*
- "We want to make you as comfortable as possible"*
- "Is there anything else I can do for you?"*
- Make eye contact when speaking+

Caring Behaviors=
- Self-introduction to patient and family
- Daily bedside discussion for at least five minutes to revisit the patient's care plan
- Calling the patient by his or her preferred name
- Appropriate handshake or touch

*Source: Gutter E., Marinaro M.: Words...the most powerful drug. *The Satisfaction Monitor*, Jan.-Feb. 2002, pp. 1-3. . Http://www.pressganey.com/research/resources/satmon/text/bin/127.shtm (accessed Sep. 23, 2003).
+Source: Baker S. K.: *Managing Patient Expectations: The Art of Finding and Keeping Loyal Patients*. San Francisco: Jossey-Bass, 1998, p. 73.
=Source: Dingman, S. K., et al.: Implementing a caring model to improve patient satisfaction. *J Nurs Adm* 29:30-37, Dec. 1999.

Staff Sensitivity. Answers to the question regarding "staff sensitivity to the inconvenience that health problems and hospitalization can cause" indicate staff awareness of and sensitivity to a patient's hopes, dreams, likes, loves, family, and self-perceived roles. Press has stated:

> Staff must be sensitized to the need to elicit patient concerns not only about the course of treatment, but also the effect of the disease and hospitalization on their lives and perceptions of self. All hospital staff empathize with patients; however, to have an effect this empathy must be *perceived* by the patient.[104(p. 69)]

To this end, standard, empathic communication behaviors[134,141] (Table 6, page 10) and simple caring behaviors[142] improve patient satisfaction and perceptions of quality (Table 7, page 10)[141–144] while decreasing emotional distress.[145] Patients consider their emotional sense of well-being an outcome of quality nursing care and expect nurses to make them feel "better," "more comfortable," "more at ease," "more positive," and so on.[146,147] Unfortunately, a systematic review of studies suggests what could be inferred from the survey results—that patients do not perceive empathy to be a common nursing behavior.[148]

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